WORLD HEALTH ORGANIZATION
EUROPE

Child and adolescent health and development

Measuring quality and coverage of services for adolescents

Report of meeting
12-15 May 2008
Kyiv, Ukraine

Abstract

Addressing the needs of adolescents is a challenge that goes well beyond the role of health services alone and requires a legal framework, social policy, safety of communities, and opportunities for education and recreation that are key to adolescent development. Health services can play an important role in helping adolescents stay healthy and complete their journey to adulthood by supporting young people to achieve good health, treating those who are ill, injured or troubled, and reaching out to those most at risk. If adolescents do not find services relevant and attractive, they are likely to rely on resources outside the formal health service provision system, such as home remedies, traditional methods of contraception, clandestine abortion, or getting medicines from shops or traditional health practitioners. To address these issues, a number of specialized adolescent-friendly approaches have been developed, and are being implemented, with the view of providing adolescents with high quality, medically sound and safe services. A regional workshop on *Quality and coverage measurement for youth friendly health services* was held in Ukraine, in May 2008, with the goal of building Member States' capacity in quality measurement and coverage of youth friendly health services, as well as in planning for youth friendly quality assessments.

Keywords

Address requests about publications of the WHO Regional Office for Europe to:
Publications
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø, Denmark
Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the WHO/Europe web site at http://www.euro.who.int/pubrequest.

The World Health Organization does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use. The views expressed by authors or editors do not necessarily represent the decisions or the stated policy of the World Health Organization.
The World Health Organization does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use. The views expressed by authors or editors do not necessarily represent the decisions or the stated policy of the World Health Organization.

Abbreviations

AFHS	Adolescent friendly health services
MARA	Most at risk adolescents
MARYP	Most at risk young people
MoH	Ministry of Health
NGO	Nongovernmental organization
PHC	Primary health care
QA	Quality assurance
STI	Sexually transmitted infections
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO-Europe	WHO Regional Office for Europe
WHO-HQ	World Health Organization, Geneva
YFH	Youth friendly health
YFHC	Youth friendly health care
YFHS	Youth Friendly Health Services
YFS	Youth friendly services

Contents

1 Executive Summary

Addressing the needs of adolescents is a challenge that goes well beyond the role of health services alone. The legal framework, social policy, safety of communities and opportunities for education and recreation are just some of the factors of civil society that are key to adolescent development. However, within an integrated approach, health services can play an important role in helping adolescents to stay healthy and complete their journey to adulthood: supporting young people who are looking for a route to good health, treating those who are ill, injured or troubled and reaching out to those who are at risk[1].

Adolescents will not use services if they don't find them relevant and attractive and will be more likely then to rely on resources outside the formal health service provision system, such as home remedies, traditional methods of contraception, clandestine abortion, or getting medicines from shops or traditional health practitioners (Nelson et al., 2000). To address these issues, a number of program initiatives have been developed and are implemented which have specialized approaches to provide adolescents with services that are of high quality and medically sound and safe. Such service approaches are referred to as being *adolescent-friendly*[2]**.**

A regional workshop on *Quality and coverage measurement for youth friendly health services* was held in Kyiv Ukraine, in May 2008, organized by WHO and UNICEF, with a view to building Member States' capacity in this field. Workshop sessions covered subjects such as quality assurance in the context of young people's sexual and reproductive health, measuring quality and coverage of youth friendly services (YFS) and monitoring and evaluation of young friendly health services (YFHS). During field work, participants were able to perform data collection using WHO tools, followed by an evaluation of the tools and suggestions for their improvement. Country teams also developed plans of action for survey of YFS implementation.

2 Background to the WHO tools for monitoring and evaluation of youth friendly services

In order for services to be considered *adolescent-friendly*, WHO has defined the dimensions of quality that should be met:

- Accessible and equitable: All essential health services that adolescents need provided in ways that makes it possible for *all* adolescents to use them.
- Acceptable: health workers and health facility staff trained to provide services to young people that are respectful and ensure privacy and confidentiality.
- Appropriate: If an adolescent client seeks help for management of a sexually transmitted infection and this is not provided, the point of service delivery is not meeting his/her needs.
- Effective: Necessary skills, equipment and supplies in place to provide quality services for adolescents

Over the last five years, countries in the European Region have made important progress towards building networks of YFHS. Still, valid and reliable assessments of services covering all dimensions of quality remain a challenge. WHO has therefore developed processes and instruments to assist district health managers and managers and staff at health facilities to improve the quality of their services for adolescents and young people through a list of Essential Adolescent-Friendly Characteristics constructed around five dimensions of quality. The completion of adolescent-friendly assessment activities will help identify whether services and systems are *adolescent-friendly* or, if not, where and how improvements can be made[3]. A number of Ministries of Health (MoH) have made a commitment towards quality

[1] *Adolescent Friendly Health Services — An Agenda for Change*. World Health Organization October 2002.

[2] "*Adolescent-friendly health services have policies and attributes that attract adolescents to the facility or program, provide a comfortable and appropriate setting for adolescents, meet the needs of adolescents and are able to retain their adolescent clientele for follow-up and repeat visits." (Senderowitz, 1995)*

[3] The process and tools were tested, adapted and applied in Mongolia and the Russian Federation.

improvement of YFHS, and partner organizations have answered positively to the call to support this process in the coming years.

Another challenge is YFHS coverage, the health service's ability to interact with (deliver interventions to) its target populations. Coverage is often used as a synonym of access, to denote the percentage of the population needing a service who have access to it. A classification has been developed for coverage of health services, which can also be applied to other types of interventions[4].

- Availability coverage: People for whom the service or intervention is available.
- Accessibility coverage: People who can use the service.
- Acceptability coverage: People who are willing to use services.
- Contact coverage: People who actually use services.
- Effectiveness coverage: People who receive effective services

One of the challenges in measuring coverage is that different techniques are required for the general population and most at risk adolescents (MARA). While measures to prevent heterosexual transmission, especially targeted at those with high risk partners, and prevention among young people is essential, the features of the HIV epidemic in the European Region clearly show that interventions to control HIV among intravenous drug users (IDU) should be the cornerstone of HIV prevention strategies[5]. Therefore, measuring the coverage of MARA is essential to know if programmes and interventions actually reach them.

Based on this multi staged model of coverage, WHO has developed a process to measure coverage in connection with quality measurement, including assessment of accessibility and assessment of contact coverage (people who actually use the service), as well as efficiency of services at youth clinics (specific effectiveness coverage). The application of these processes and tools has several advantages:

- Overall assessment of quality along all dimensions,
- Quantitative analysis of complex qualitative information using a scoring system.
- Comparisons between different offices/clinics and even countries, particularly important for monitoring and evaluation of programmes and critical evaluation of pilot projects to ensure that really positive experiences are expanded.
- Full sample of easily adaptable questions attached to different quality characteristics.
- Triangulation of information through different sources (providers, clients, community members).
- Quick checks, preferably by projects rather than a full quality monitoring, as extensive quality assessments may not be applicable in all settings, and some projects may have limited resources available.
- Can be used for both external assessments and provider self-monitoring.
- Measurement of accessibility, contact and effectiveness coverage.
- Integrated into an existing quality improvement system, can lead to considerable quality improvements at relatively low cost.

The process is implemented in three stages:

- Stage I**:** country teams trained in using WHO tools and processes, to build capacity in their application.
- Stage II: national teams established to plan for the quality and coverage survey, and carry out preparatory work.
- Stage III: surveys conducted, results analysed and improvement measures developed.

[4] Tanahashi, 1978. «Health service coverage and its evaluation.»/ Bulletin of the World Health Organization, 56(2): 295-303)

[5] HIV / AIDS Surveillance in Europe. End-year report 2006. 2007, No. 75

3 Workshop on Measuring Quality and Coverage of Services for Adolescents

3.1 Outcomes of the workshop

- Ability to plan YFHS quality assessments.
- Ability to conduct field data collection on quality measurement using various methods.
- Ability to score, summarize, present data, plan for improvements and monitor facilities over time.
- Country specific draft plans for integration of the quality assessment process into existing YFHS quality improvement approaches.
- Improve knowledge of coverage concept and ability to identify support required to organize coverage survey of youth-friendly clinics for adolescents and young people.
- Identify country-specific needs for developing YFHS quality standards.
- Country-specific plans for application of YFHS quality measurement.
- Workshop report reflecting content and processes.

3.2 Objectives

- Build Member States' capacity in planning YFHS quality assessments.
- Build practical skills in field data collection using various methods.
- Build Member States' capacity in scoring, summarizing, presenting data, planning for improvements and monitoring facilities over time.
- Explore how the quality assessment process can be integrated into existing YFHS quality improvement approaches.
- Introduce concepts of accessibility, contact and effectiveness coverage of youth-friendly clinics for adolescents and young people and measuring coverage in connection with quality assessment.
- Identify Member States' needs in developing national YFHS quality standards.
- Develop country specific plans in applying quality and coverage measurement of YFHS.
- Document workshop processes to enable replication in other European Member States and other WHO regions.

3.3 Organization

The regional workshop on *Quality and coverage measurement for youth friendly health services capacity building* was held in Kyiv, Ukraine, from 12 to 16 May 2008. Representatives from the Republic of Moldova, Kazakhstan, Kyrgyzstan, Tajikistan and Ukraine were present. Workshop activities included country presentations, lectures by WHO and UNICEF specialists and temporary and special advisors in the different programme areas, group work, field work and plenary discussions. As background material, participants were supplied with a draft version of *Quality Assessment Guidebook – a guide to assessing of health services for adolescent clients*, assessment questionnaires, and an introduction on how to develop national YFHS action plans. Field work on data collection was carried out at the Ohmatdet Clinic, City Outpatient Clinic and at the YFCH at Children's Hospital no. 6, all in Kyiv. The workshop was organized by WHO and UNICEF.

3.4 Proceedings

3.4.1 Day 1

The workshop was opened by Dr Valentina Borisovna Pedan who, in the name of Ukraine MoH, welcomed participants and wished them success in their endeavours to improve health care services for young people and adolescents. Following, the organizer agencies – WHO and UNICEF through their representatives – thanked participants and their countries for their interest in contributing to the development of tools for monitoring and assessing care and services for young people. Participants were also greeted by the head of UNFPA country office in Ukraine.

Dr Valentina Baltag of WHO/Europe then gave an overview of workshop objectives and described in detail the activities that would take place over the following days.

Participants where then asked to pair up with someone they had not met before and exchange information on how each is involved with and his or her role in implementing YFHS activities and quality assurance, as well as personal details. This exercise had the purpose of creating an informal and warm atmosphere. Each participant then introduced his/her partner to the full plenary.

3.4.1.1 Session 1 – Quality assurance in the context of young people's sexual and reproductive health

The aim of the session was to set the scene, within WHO/Europe and UNICEF priorities, for supporting Member States in the area of young people's development and health, with particular emphasis on sexual and reproductive health. As an introduction to workshop activities, two presentations were made on quality assurance in the care of young people, including those most at risk. Dr Ruslan Malyuta of UNICEF focused on the concept of quality, defining quality as the degree to which health or social services meet or exceed established professional standards and user expectations. Quality is often determined by the health system or its infrastructure rather than on the performance of individual health providers.

Quality assessment is important because, when quality improves, care becomes more efficient and effective. Quality is determined through identifying differences between expected and current level of provider performance, based on common standards that will allow identification of areas for possible improvements that are, in consequence, based on accurate and measured data. Quality improvements should consider best practices and are best achieved through continual, small and incremental changes.

In the area of youth friendly health services, quality can predict outcomes in contraception counselling, sexually transmitted infections (STI) prophylaxis and screening for cancer, and are associated with factors such as patient/provider interaction, infrastructure and evaluation at facility and provider performance levels. As his final point, Dr Malyuta said that an effective tool in monitoring and evaluation is the comparison of outcomes between health institutions within a country and between countries.

Dr Valentina Baltag gave an overview on this same subject from a regional perspective. Dr Baltag said that some strategic information is available in all countries: however, information on coverage is missing; coverage is mainly understood as availability of services. In many countries, adolescent health is among national priorities. Some countries have developed national strategies, implementation of which has been initiated through development of a network of youth friendly health centres. To date however, no assessments have been carried out on the centres and, therefore, nothing is known of the quality of their services. Further, it is not known how many adolescents are in fact covered and how many know about them and have actually been to a centre.

The effectiveness of the centres may also be hampered by policy and legislation, some of which make it impossible for adolescents to apply for services due to age or parental permission. Where such legislation exists, a careful review should be carried out and modifications introduced where necessary.

To advance adolescent development and health, the following activities need to be given priority:

(1) availability of strategic information based on common indicators to allow monitoring of trends and comparisons between facilities and countries;
(2) adoption of a human rights based approach for updating and/or introducing supportive and evidence-based policies;
(3) availability of quality services and commodities, with emphasis on effectiveness, coverage and equity; and
(4) strengthening and supporting related sectors, such as school health services.

In countries with limited resources, it is particularly important to make existing services youth friendly, rather than setting up new centres or dedicated clinics. Although the two strategies should complement each other, in countries where the institution of family medicine is developing, strengthening the primary health care (PHC) to become age-appropriate should be considered the key strategy.

3.4.1.2 Session 2 – Country presentations

Each participating country – Kazakhstan, Kyrgyzstan, the Republic of Moldova, Tajikistan and Ukraine – made a short presentation of the status of YFHS at the national level. Countries had been asked to include an overview of their YFHS network; why they feel quality and coverage needs to be measured; and address issues of health systems and quality assurance (QA) for YFHS.

The presentations showed common trends: all countries have an YFHS network, although at different stages of implementation and based on different models. All have a national strategy and/or policy that recognize young people as a priority. All acknowledge that, although quality assessment is an important issue, it has so far been overlooked. Participants agreed it is important to distinguish between YFS, YFHS and medical services.

Kazakhstan – Dr Sholpan Karzhaubaeva

Kazakhstan initiated its activities in the area of youth friendly health centres (YFHC) in 2002 with the mapping of the quality of existing services. Workshops on organization and administration of centres and health-social counselling for adolescents were held through 2003 and 2004. The first centre was opened in 2004; there are now six of these. A resolution was issued in 2006 by MoH: *Introducing youth friendly services,* and a programme on *Healthy life* was set up in 2007. Emphasis has been given to training of health care and counselling providers, and a programme dealing with medical and social assistance for adolescent has been approved by the MoH, covering a two-year certified course. Kazakhstan is working on developing long and short term indicators to monitor the level of QA in the care of adolescent and young people.

Kyrgyzstan – Dr Galina Chirkina

Children and adolescents continue to be the most vulnerable groups in Kyrgyzstan's population. This has been highlighted by significant changes in both the education system and the health care reforms made necessary by economic instability. One of the objectives of the National Reproductive Health Strategy for 2005-2015 has been the reproductive and sexual health of adolescents. YFHS have been available since 2002 at PHC facilities supported by NGOs providing, among others, education on reproductive health issues and HIV/AIDS and STI prevention. Special emphasis in 2005-2007 was on training of health care providers and specialists in addressing the needs of young people, and on the development of quality standards for YFHS. A working group has been set up by the MoH to develop quality standards based on priority health and development problems of young people in Kyrgyzstan.

Republic of Moldova – Dr Galina Lesco

Activities on YFHS were initiated in 2001-2, when three pilot clinics were set up with the support of UNICEF. In 2003, a first national survey was carried out to determine knowledge, attitudes and practices in meeting the needs of young people and how they can best access health services. Training of health care providers and counsellors for YFS started in 2004. By 2005, there was a network of eleven YFC and by 2006 approximately 100 000 young people had used these services. Two national strategies were developed and approved by the Moldovan government: on youth and on prevention of HIV and STIs. The development of quality indicators started in 2006 with the support of WHO and UNICEF and is now in the final testing phase. Expansion of YFS, with focus on public health institutions, development of statistical data forms and linking YFS to primary health care is an ongoing process. Evaluation and monitoring are seen as essential for identifying best practices that can be the basis for improving the quality of care and services.

Tajikistan – Dr Rakhim Dadabaev

Activities to improve young people and adolescent health were initiated in 2003. A number of MoH resolutions have been issued covering the health of young people, including for HIV/AIDS and human reproduction. A national programme on youth health development for 2006-2010 has been developed and implementation of a strategic plan for AIDS and STIs was initiated in 2007. National indicators to monitor the quality of services were introduced in 2007 and performance indicators are now being developed. The MoH feels that monitoring and evaluation are needed to measure the efficiency, effectiveness and coverage of care and accessibility to services for identifying the level and improving outcome of care. YFHS in Tajikistan involves a wide partnership with nongovernmental organizations, United Nations agencies and other interested organizations.

Ukraine – Dr Valentina Pedan

The MoH has issued two specific pieces of legislation for YFHS: improving medical care for adolescents (2004); and providing medical-social care for children and young people (2005). The MoH has submitted two national programmes – reproductive health of the nation for 2006-2015 and healthy children for 2009-2012 – for approval by the Cabinet of Ministries. These are based on an observed declining trend in adolescents' health, mostly due to insufficient resources and availability of medical services. To date, there are 44 YFHCs in the country and emphasis is on training of trainers and training of specialists in this area. The expected outcome will be improving the quality of services provided by the YFCs through certification and, specifically, implementation of HIV testing procedures.

3.4.1.3 Session 3 – Measurement of quality and coverage of YFHS and HIV prevention

The session gave a general overview of the concept of quality and the links between quality improvement, coverage and costs. Dr Paul Bloem, WHO headquarters, introduced the WHO framework for measuring achievements of programmes under implementation. He explained the links between quality, coverage and cost, the three essential points in measuring effectiveness. A logical model *Mapping adolescent programmes and monitoring* has been developed to identify what requires monitoring, that uses four basic indicators: interventions (policies/activities), determinants (risk/protective factors), behavioural and health and development outcomes. Dr Bloem stressed that, to be able to measure the quality of services at the national level, the first step is to determine what constitutes good and adolescent friendly services.

In a second presentation, Dr Bloem introduced the WHO vision of how to measure quality and coverage of YFHS. A tool for assessing quality of YFS has been developed and is recommended by WHO, which includes identification of the data required for monitoring purposes. Dr Bloem stressed that measuring quality should be considered part of the monitoring programme. Quality can mean different things depending on the type of outcome desired. For instance, for production it would mean *fitting the criteria adopted;* in marketing, meeting the needs and wishes of clients.

WHO uses those characteristics accepted at global level (2000); for example, equity; accessibility; acceptability, appropriateness, effectiveness and efficiency. WHO recommends a number of tools for different purposes: targeting care providers, support staff, management, health facility; young clients and young people in the community. It is up to each country to select those most appropriate for its conditions. In the case of: *Does improving quality improve coverage?* current evidence suggest that improving conditions in the facility, linked to capacity building of health care providers and efforts to increase community demand, does increase use of services by young people.

- **Discussion period**

During the discussion period, participants emphasized the demand for quality measurement processes to reflect the needs of most at risk young people (MARYP).

- **Group work: getting familiar with the tool**

Participants were divided into country teams and asked to:

- look through the tool very carefully, with special attention to pages 2-4, *main characteristics of YFHS* (5 main characteristics with descriptions): do these characteristics answer the question on what is understood by *quality*? Is there anything that should be added?
- look through the data collection tools for interviewing adolescent clients, care providers, support staff and health facility management; and
- look through tools for community members and outreach workers.

3.4.2 Day 2

The day's activities started with summary of the subjects covered on Day 1 and an overview of activities planned for Day 2. As a continuation of the session on measurement of quality and coverage of YFHS, Dr Tatiana Kozhukhovskaya made a presentation on YFHS in the Russian Federation. The first YFHCs were set up in 1993; their number increased rapidly throughout the 1990s. At present, there are 78 centres; of these, 22 are in St Petersburg.

Cooperation with WHO in surveying the quality of YFHCs and assessing coverage was initiated in 2003, using international standards. The first survey was conducted in Tomsk, Western Siberia, with specific questionnaires for clients, clinic workers and administrators. As the survey progressed, the questionnaires passed through various stages of adaptation, correction, testing, analysis of results and final version. The survey covered seven youth friendly health (YFH) clinics and 360 clients and 106 staff were interviewed.

Results showed that it is possible to compare services with different structures, main activities, staffing, sources of financing and other criteria. Evaluation was carried out by using a points system, ensuring more objective conclusions. With this methodology, comparison of similar parameters becomes more visual and stimulating, allowing development of clinic certification as Youth Friendly Clinics.

The experience showed that a successful survey requires that the following conditions be in place:

- High level of expertise, objectiveness and friendliness of surveying team
- Availability of funding and staff time
- Commitment of centre, community and/or city health managers to improving services, and their acceptance of possibly critical comments
- Good data collection practices in youth clinics
- Availability of statistic data
- Skilled survey participant skills in conduct interviews and facilitating focus groups
- Good survey team work.

Dr Kozhukhovskaya suggested that the questionnaires should be tested in a further a pilot survey before major research is initiated.

3.4.2.1 Session 4 – Group work: Reviewing the tools

Participants were divided into groups, each being requested review the tool scoring system (page 18 of the Russian version). Feedback/comments should focus on different parts of the WHO tool: main characteristics for YFHS, tools for data collection, and the scoring evaluation system. Feedback from the groups is summarized below.

1. Main characteristics:

- Illustrate the principles of the *youth friendly approach*.
- In general, complete and clear.
- National quality standards need to be reflected.
- Characteristics should be flexible to reflect changing national needs and/or conditions.
- Under *accessible*, include whether YFHC is conveniently situated.
- Pre-test consultation.
- Availability of:
  - HIV testing;
  - pregnancy testing; and
  - gender component.
- Effectiveness of centre.
- Client participation in quality evaluation.
- Emphasis on point 6 – principles of anonymity.
- Points 7 and 8 – term *community members* clearly defined.
- Points 6 and 9 – considered contradictory (point of major discussion).
- Point 9 – restrictive as regards confidentiality and treatment;
- Correlation between *preventive-consultative* and *diagnostic-treatment* services.
- The term *impartial* to be substituted by *equal*.
- *Accessibility* should include *territorial accessibility*.

2. Evaluation system by points:

- Clear.
- Acceptable.
- Comprehensive.
- Easy and informative.
- Basis for developing criteria for accreditation.
- Two questions to be combined into one (e.g. 5 & 6).
- No choice between *yes* and *no*.
- Computerized processing of results.
- Allows different levels for evaluation (e g, separate results for managers).

3. Tools for data collection:

- Allows triangulation.
- Tools not very sensitive to needs of MARYP; for instance, evaluation of *syringe exchange point* (availability, working hours, can anyone come), etc., is not reflected.
- Medical component modified depending on standard service package.
- Questionnaires adapted to national quality standards.
- Each question with a clear objective (how will results be used).
- Some questions complicated linguistically – need to be simplified so all adolescents understand;
- Not all questions correctly formulated.
- Many questions formulated to result in a negative answer; change to positive;
- Country adaptation necessary.
- Emphasis only on medical services.

- Some medical terms removed in adolescent questionnaire.
- Some questions to be clearer.
- Some questions to be rephrased so as to be understandable by general population.

3.4.2.2 Session 5 – Measuring coverage of YFHS

In her presentation on measuring coverage of YFHS, Dr Krishna Bose introduced a framework to help define coverage and how it can be measured:

- Availability coverage: services available to all young people; national or regional level;
- Accessibility coverage: do adolescents know about the service, can they afford and reach it (a service may be available but not accessible); community level;
- Acceptability coverage: typically lower if adolescents are told service is not good or does not guarantee anonymity, etc.; community level;
- Contact coverage: shows the percentage of adolescents who have contacted a facility and received care; facility level; and
- Effectiveness coverage: how many of those who had contact with the service actually received care that resulted in positive changes in their health status; usually not measured.

Dr Bosse then gave an overview of the links between quality, coverage and cost of interventions. She explained that a number of coverage indicators are already available and are used by Member States worldwide. As examples, she used indicators covering HIV and STIs, presenting data from global surveys.

In conclusion, Dr Bose gave the United Nations millennium target for HIV: *By 2010 at least 95% of young people 15-24 have access to information, education, including peer and youth-specific HIV education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection.*

Dr Bose then proceeded to go through the coverage questionnaire in detail, reviewing its important components and explaining possible ways the tool could be simplified and/or modified. Dr Bose explained that questions are designed to meet the needs of the general population but can also be applied to MARA without significant changes.

Following Dr Bose, Dr Tatyana Kozhukhovskaya gave a presentation measuring coverage of YFHS for teenagers, explaining how the tool was used for a research project in St Petersburg to evaluate the coverage of young people by medico-social services. The main stages of the research were:

- Collection of socio-demographic, epidemic and statistical data;
- Mapping of institutions providing medico-social reproductive health services to adolescents (qualitative and quantitative indicators); and
- Data collection, mainly through street interviews, using appropriate methodology.

Results showed the target group to be huge (70%) and that, while adolescents between 15 and 19 are sexually active, only 5-7% uses contraceptives.

3.4.2.3 Session 6 – Field Work: Preparation

In preparation for field testing of the questionnaires to take place on Day 3, participants were divided into three groups. Each group was then divided into five subgroups, two persons in each, to interview: (1) facility managers; (2) providers; (3) support staff; (4) facility clients; and (5) young people in the community.

The following principles were followed when assigning group participants and tasks:

- All countries represented at each facility;
- All countries to have the opportunity of testing every questionnaires;
- Heads of facilities to be interviewed by senior participants;

- Each interviewee to be interviewed only once; and
- Each participant was given a core task; time allowing, he/she would test another tool.

Participants were asked to prepare feedback on their results, taking the following points in consideration: does the tool work; did the people interviewed understand the questions; are the questions adequately structured; and do the questions reflect the given dimension of quality. People being interviewed should be asked if they found taking part useful and/or interesting and whether they had anything to add they felt to be important.

An exercise was then held to practice before filed interviews. Members of each group worked together, testing the tool on each other.

- Group 1 – City Outpatient Clinic:
  - Facilitators: Paul Bloem, Christina Rogala, Ruslan Malyuta.
  - Subgroup 1 (facility managers) – Gulnara Kulkaeva (Kazakhstan); Zhamilya E. Usupova (Kyrgyzstan).
  - Subgroup 2 (providers) – G. Ahmedjanova (Tajikistan); Lubomira Kutnevich (Ukraine).
  - Subgroup 3 (support staff) – Petru Crudu (Republic of Moldova); Olena Anoprienko (Ukraine).
  - Subgroup 4 (clients): Oksana H. Bogdanova (Kyrgyzstan); Rakhim Dadabaev (Tajikistan).
  - Subgroup 5 (adolescents in community): Meder Omurzakov (Kyrgyzstan); Ludmila Bologa (Republic of Moldova).
- Group 2, Ohmatdet Clinic:
  - Facilitators: Tatiana Kozhukhovskaya, Krishna Bose.
  - Subgroup 1 (facility managers): Galina Morari (Republic of Moldova); Elvira A. Toyalieva (Kyrgyzstan).
  - Subgroup 2 (providers): Galina Eduardovna Chirkina (Kyrgyzstan); Galina Lesco (Republic of Moldova).
  - Subgroup 3 (support staff): D. Dj Huseinova (Tajikistan); Lydia Romanenko (Ukraine).
  - Subgroup 4 (clients): Svetlana Moroz (Republic of Moldova); Lyudmila Parhomenko (Ukraine).
  - Subgroup 5 (adolescents in community): Raisa Schevchenko (Ukraine); A.R. Berdialiev (Tajikistan).
- Group 3: YFHC at Children's Hospital no. 6:
  - Facilitators Anastasiya Dumcheva, Valentina Baltag, Olga Petersson.
  - Subgroup 1 (facility managers): Obidjon Aminov (Tajikistan); Lyubov Semenyuk (Ukraine).
  - Subgroup 2 (providers): Gheorghe Railean (Republic of Moldova); Tetyana Gonchar (Ukraine).
  - Subgroup 3 (support staff): Gulnara Atantaeva (Kyrgyzstan); S. Izatullaeva (Tajikistan).
  - Subgroup 4 (clients): S. Izatullaeva (Tajikistan); Sholpan Karzhaubaeva (Kazakhstan); Victoria Ciubotary (Republic of Moldova).
  - Subgroup 5 (adolescents in community): Galina Bobyr (Ukraine); Anara T. Ibraeva (Kyrgyzstan).

3.4.3 Day 3

3.4.3.1 Session 6 – Field work: Results

After return from field testing, each team was asked to use the scoring sheet to calculate score for a given characteristic based on data collected during field work. Every group selected a rapporteur. A summary of their results are given below:

Facility managers:

1. What went well:
    - Most questions well understood and accepted.
    - Questionnaire not too long – time frame for completion: 25-30 minutes.
    - Most questions well structured.
2. What was difficult:
    - There were four requests for additional clarifications.
    - One interviewee thought the meaning of *community* should be clearer.
    - *Privacy* and *confidentiality* caused difficulties during scoring.
3. What should be changed/added:
    - Sequence of questions should be changed.
    - Questions 3 and 4 should be merged with a clear definition of category of adolescents (features).
    - *Community* in question 10 should be more precise; *medical* services should be substituted by *friendly*.
    - Terms should be consistent throughout the questionnaire.
    - Questions need to be adapted for the national level.
    - For evaluation purposes, the YFHC questions on human resources policy, inter-territorial and nongovernmental (NGO) collaboration should be added.

Providers

1. What went well:
    - No interviewee refused to answer questions.
    - Practically all interviews took less than 30 minutes.
    - Felt as a good introduction to using the tools.
2. What was difficult:
    - Providers not specialized in YFHS.
    - Almost all questions need revision (complex questions should be divided up, explanations on context required).
    - Question 8 – interviewees did not understand *members of the community*.
    - Question 9 – *confidentiality* needs explanation as people understand it differently.
    - Question 13 – revised to *do you have guidelines for referrals*?
    - Question 14b – doesn't work; needs further clarification (interviewees answered yes; it is important to know how….
    - Question 17b – most interviewees answered they didn't feel the need for further training.
    - Question 20 – in its unchanged form, totally incomprehensible.
3. What should be changed/added:
    - Job titles should match terms used in the country (e.g. "the term young nurse" does not exist in many countries);
    - Question 3d – why is it being asked?
    - Question 9 – should be divided into components of confidentiality;
    - Question 15 – should include other questions; *not applicable* needs to be added, in case the facility doesn't provide the service;
    - Question 21 – should be revised to read *time for each client*; and
    - Many questions need revision (greater precision).
4. Points for discussion:
    - Identical questions in different tools and scoring sheets slightly different;

- Too many questions in some tools;
- Length of interview is important; young people get tired and answer without thinking; interview should not be more than 15-20 min for YP; for providers, 30 min is adequate.
- Some terms are understood differently even by providers (i.e. *confidentiality*, *community*, *reproductive health*) definitions/examples in footnote or glossary would be useful;
- When deciding on which questions and how many, it should be clear what expected answer should be; and
- There are perhaps more questions than necessary since there is at present no evidence on what works and what doesn't in attracting clients and influencing health outcomes, so the tool covers a broad range of issues. The tool is not a questionnaire as such but a bank of questions from which countries may choose. The order of questions is strange as it follows the characteristics, but there is no logic flow in the interview. Country adaptation needed.

Support staff

1. What went well:
    - Friendly.
    - Nobody refused to be interviewed.
    - Good contact.
    - Optimal questionnaire.
2. What was difficult:
    - Question 5 – difficult to understand, subjective and doesn't reflect quality.
3. What should be changed/added:
    - To be added: tick boxes.
    - Question 5 – rephrased: *Is there a category of young people that you have ever refused services*?
    - answers: *yes* or *no*;
    - Add: 2.1 – *do you know what YFHS implies?* Answers: *yes* or *no*.
    - Add: 2.2 – *do you know about the package of services delivered by your YFHC?* Answers: *yes* or *no.*
4. Points for discussion:
    - Add question like *why did you choose to work here*; *do you feel comfortable in working here*; *where you given special training about young people*.

Clients of clinic

1. What went well:
    - Questions 8, 9, 10.
    - Timeframe.
    - No special difficulties in completing questionnaires.
2. What was difficult:
    - Not all questions can be answered *yes* or *no*.
    - Some questions should be divided into two.
    - Some questions need to be revised for language.
    - Words such as *secretary*, *reproductive health* need to be changed or explained.
    - Some questions should be deleted.
3. What should be changed/added:
    - Question 6 to be divided into two;

- Question 7 should read: *Is there an information stand with a document listing centre services?* Answer: *yes* or *no*;
- 7a: *Do those services answer your needs?*
- 11: "Secretary" should be substituted by «receptionist»;
- 13: delete;
- 32: incorporate into 33;
- 35: delete, leaving 35a – *are your satisfied*?;
- 39: delete;
- 42: delete; and
- 49 should read *are contraceptives and condoms available in your facility*?

4. Points for discussions:

    - Revise sequence of some questions.

Adolescents in the community (coverage tool)

1. What went well:

    - Satisfactory communication.
    - No negative or rude comments.
    - Adolescents eager to answer.
    - Average time of interview: 15 minutes.
    - Useful information; most adolescents know about YFHS.

2. What was difficult:

    - Finding adolescents at 01 p.m.
    - Questions about sexual behavior.
    - Poor translation
    - Many questions are understood as personal
    - Age of some interviewees.
    - Questions 50 to 56 quite difficult to make in the street.

3. What should be changed/added:

    - Translation.
    - Shorten questions.
    - More precise questions (30, 31).
    - Delete *reproductive health*.
    - Add section on how to start interview, introductory talk; add characteristics/behaviours of a good interviewer.
    - Clarify services questions 7 and 8.

4. Points for discussions:

        – Addition of glossary

The scoring exercise

Dr Ruslan Malyuta presented on behalf of the group on scoring of characteristics 9 and 10. There were no problems or different opinions on 9 where the percentage is 100%. With regard to 10, there are problems with translation and formulation of the questions.

3.4.4 Day 4

3.4.4.1 Session 7 – Integrated YFHS: the role of family medicine

Opening the session, Dr Valentina Baltag welcomed members of the Association of Family Medicine who had been invited to join the workshop for this session. The new participants introduced themselves.

This was a joint presentation by Professors Trevor Gibbs and Grigory Ivanovich Lysenko, and Dr Liudmila Victorovna Khimion on how family medicine can contribute to improving access to YFHS. The objective was to present the strengths and perspectives of family medicine with focus on services for adolescents. The reason for this session in the context of quality and coverage with YFHS was that, in many countries in the region, YFHS developed mainly as dedicated services, even if their physical location is often within a PHC facility. However, almost no efforts have been made to ensure PHC practitioners can deliver services sensitive to young people. High coverage is also more likely through PHC rather than dedicated clinics/offices.

Family medicine can be defined as a scientific and academic specialization with its own evidential and research base. It is also a clinical speciality for providing primary care. The family physician is the first care provider a patient will encounter in the health care system. He/she is responsible for the state of health of the population, guiding patients towards a healthy lifestyle, preventing and/or curing disease. The family physician is the most important provider in the PHC system.

A short description of family medicine in Ukraine by Dr Khimion followed. In Ukraine, this is a priority for the MoH. There are 7 000 certified family physicians and over 3 000 state-operated out-patient clinics; the Ukrainian Family Planning Association covers 17 regional associations.

In general, family doctors are responsible for delivering first level services to the whole population, including young people and adolescents. They should advocate for their patients, represent their interests, including social aspects. The family doctor should focus on the general health and well-being of the patient and, ideally, be in long-term contact with the family to facilitate disease prevention. In Ukraine, family medicine is a priority for development of the health care system and its reform, with a view of facilitating European integration.

Discussion period

A question was asked regarding how long a family doctor consultation should last. The reply was 12 minutes; a home visit would take longer. Participants pointed out that a counselling session for young people may take more than 12 minutes, which needs to be considered when designing standards for the length of a consultation. Another query regarded skills of family doctors to handle different groups within the population, especially adolescents on such issues as mental, sexual and reproductive health. The reply was that the Ukrainian education package in post graduate medical institutions has a full programme in specialized consultations. However, the majority of PHC providers is not well oriented on how to deliver services sensitive to young people's needs and be accepted by them. In rural areas, family doctors cover all aspects of health care; in bigger towns, some aspects are shared with other specialists.

Professor Gibbs added that, as family medicine develops as a team approach, a progress evaluation should be carried out.

3.4.4.2 Session 8 – Monitoring YFHS

Dr Lydia Romanenko, head of the YFCs Monitoring Centre at the Okmatdyt Ukrainian Hospital, made a presentation on the monitoring passport used in the YFHC in the city of Lvov. Dr Romanenko gave an overview of current legislation for young people's health and of the modules for training health providers. With regard to the centre itself, she explained its objectives and functions, staffing and referral structure, age and territorial structure of clients, their reasons for contacting the YFHC (mainly for treatment, rarely for psychological support) and how preventive services are conducted. The Centre also carries out data collection and produces statistics, based on both main and specific indicators.

The next part of the session was dedicated to practical aspects of planning a quality and coverage survey. Dr Kirshna Bose gave a presentation on practical issues of sampling: why it is important for quality and coverage measurement, sampling techniques and their limitations and size considerations. Sampling can be described as the selection of members of a population to observe or measure a

characteristic of interest as, for example, knowledge or reported behaviour. There are two distinct methods of sampling.

- Probability:
  - each person in a defined *universe* may be included, with results representing a *true* population value. Example: demographic and health surveys. Less prone to bias and enables comparison between surveys.
- Non-probability:
  - purposive: maximum information on key groups of interest;
  - convenience: key group at least cost; and
  - snowball/network: key informants in subpopulation identifying other members.

With reference to sample size, the following needs to be considered: aim of study; current prevalence estimate of issue of interest, and type and level of evidence: statistical power versus cost.

A presentation with reflections of a core of set indicators for national monitoring of AFHS implementation was prepared by Dr Paul Bloem and is available on the workshop CD-Rom.

Dr Bloem spoke on the subject of adaptation of pre-testing of instruments, on team selection, quality control, data entry and analysis. The suggested steps to be followed are to:

- Set up working groups and involve young people.
- Make local adaptation of tools; if national quality standards exist, adaptation of the tools should follow these.
- Design and field test tools, followed by finalization.
- Set up and train data collection team.
- Analysis and interpretation of data.
- Dissemination of data.

Dr Bloem said it should be remembered that the quality assessment in itself is not important; confirming whether improvements have been achieved is.

3.4.4.3 Session 9 – Country planning

Participants were given printed guidelines on how to develop country plans for surveys on quality and coverage of YFHS. It was emphasized that the objective should not a one-time assessment of service quality but the continued improvement and stability of YFHS. Surveys should be linked to standards of care, in turn connected to health care services packages and to the needs of adolescent target groups. The following objectives were set out:

- Goal: reason for survey on quality and coverage of YFHS.
- Task force on YFHS: clearly define objectives and priorities.
- Type: input data or monitoring progress.
- Standards: are there national quality standards for YFHS; if so, are these linked to target group priorities.
- Process: how research on quality and coverage can become part of improving quality, including accreditation of hospitals and medical licensing.
- Relations of YFHS with PHC reforms and other sectors.

3.4.5 Day 5

3.4.5.1 Session 10 – Presentation of country plans

The plans developed by country teams were presented in plenary.

- **Kazakhstan**

The focus was on objectives, necessary steps, connection with other sectors of PHC and the Institute of Family Medicine. Stages were identified as: translation, review and adaptation of tools, and setting up of the working group to decide on target groups, sampling and adapting questionnaire. A pilot survey will be carried out in two YFH centres. Timeframe: Pilot survey – June 2008.

- **Kyrgyzstan**

The team focused on steps needed to carry out survey: mapping institutions providing YFHS, working group review and adaptation of questionnaires to reflect the needs of the general population and marginal groups. A pilot survey will be carried out in four centres: two state and two NGO facilities, with a target group from 10 to 18 years of age. The next step will be to develop national YFHS standards, to be approved by the Ministries of Health, Social Affairs, Internal Affairs and Education.

- **Republic of Moldova**

The objective of the first pilot survey will be to collect data for monitoring the quality of services of care. The first step will be set up a working group to review, adapt survey tools and secure approval of quality standards recently developed with WHO support. Emphasis should be made on connecting YFHS where PHC reforms have taken place and development of mechanisms for intersectoral collaboration. A working group will be set up, followed by a three-day seminar on adaptation of tools. A first sampling will be made by the working group. A pilot survey will take place in three pilot facilities over a two-week period; the analysis of results and a final report will be completed within two months. Time frame: Set up of working group – June-July 2008.

- **Tajikistan**

The first survey will be carried out using the snowball method. An intersectoral working group will be set up, to include representatives of the Ministry of Justice, NGOs and young people. The working group will adapt the tools through triangulation and the use of focus groups. Data collection will be carried out by a specially trained outreach team. The MoH Statistical Centre will analyse data. Improvements identified by the survey will be implemented after a decision-making process involving all interested parties. The fist round of the survey will focus on three specialized clinics, targeting high risk groups of young people 15-24 (those involved in sex work, IDUs or HIV infected). A shortened version of the questionnaires will be used. Later, a further survey will cover eight additional YFH clinics.

Timeframe:

- Set up of working group ..... June-July 2008
- Data collection ..... October-November 2008
- Analysis of results.....December 2008 –January2009

- **Ukraine**

As a first step in the process, an interdepartmental working group will be set up in order to agree on objectives, identify and distributed tasks. Members will include representatives from the MoH, partner organizations, NGO, young people, as well as experts in sociology and education. Finalization of tools and questionnaires will involve, besides working group members, specialists from the area of medical academia, psychology, statistics, as well as WHO and UNICEF experts. Prior to implementation, tools and questionnaires will be tested and validated and, if necessary, further improved. Implementation will be initiated with a survey of 8-10 centres, after which data will be analysed for representativeness and validity. A second step will be identifying areas for possible improvements, their dissemination and monitoring of results. Financial implications for both the preparatory and implementation phases will include funds for training of interviewers, printing of forms, purchase of computer, software and copying equipment. It is hoped that financial assistance will come from WHO, UNICEF and UNFPA. The process, once in place, will be repeated every three to five years.

Timeframe:

- Preparation

- Set up of working group ..... 3rd/4th quarter 2008
- Adaptation and finalization ..... 4th quarter 2008
- Testing, validation of tools ..... 1st/2nd quarter 2009
- Finalization .....2nd quarter 2009

- Implementation
  - First pilot study – 8-10 sites .....2nd/3rd quarter 2009
  - Collection of data, analysis, improvements.....2010

➢ **Discussion period:**

A discussion followed on common issues – these included financial requirements for the surveys and the technical support needed from the United Nations agencies, UNICEF, UNFPA and WHO.

3.4.5.2 Closing

During the closing ceremony, Dr Valentina Borisovna Pedan, in the name of Ukraine MoH, thanked participants for their very real contribution to the positive outcome of workshop activities, as well as WHO and UNFPA for supporting the MoH in organizing this workshop and for the high quality of the technical support provided.

Dr Valentina Baltag of WHO/Europe made a retrospect of workshop objectives and encouraged participants to make an evaluation based on these objectives by completing the form provided for this purpose. In her closing remarks, she thanked Ukraine MoH for making this event possible, as well as the United Nations partner agencies, experts and participants for their valuable contributions.

Each participant was given a CD-Rom with workshop materials.

4 Programme

➢ **Day 1 – 12 May 2008**

08:30 – 09:00	Registration	
09:00 – 09:30	Opening:	
	Welcome on behalf of Ministry of Health, Ukraine	*Valentina Pedan*
	Welcome on behalf of WHO-Europe, Ukraine	*Igor Pokanevych*
	Welcome on behalf of UNICEF Regional Office	*Ruslan Maliyta*
	Welcome on behalf of UNFPA, Ukraine	*Borys Vornyk*
09:30 – 09:40	Objectives of the meeting	*Valentina Baltag*
09:40 – 10:30	Introduction of participants	
11:00 – 11:30	Quality assurance in the context of young people's sexual and reproductive health	*Valentina Baltag* *Ruslan Malyuta*
11:30 – 13:00	Country presentations	
	Kazakhstan	*Sholpan Karzhaubaeva*
	Kyrgyzstan	*Galina Chirkina*
	Republic of Moldova	*Galina Lesco*
	Ukraine	*Valentina Pedan*
14:00 – 14:30	Discussion period	

14:00 – 15:00	Measurement of quality and coverage for YFHS and HIV prevention	*Paul Bloem*
15:00 – 15:30	Discussion period	
16:00 – 17:00	Overview of the quality measurement tool	*Paul Bloem*
17.00 – 17.30	Discussion period. Home work	

- **Day 2 – 13 May 2008**

09:00 – 09:15	Feedback day 1 and overview day 2	
09:15 – 09:35	Quality measurement in the Russian Federation	*Tatiana Kozhukhovskaya*
09:35 – 10:10	Group work: Reviewing the tools	
10:10 – 10:30	Group work: generic characteristics, interview tools and scoring system	
11:00 – 12:00	Group work: Feedback, discussion	
12:00 –12:40	Overview: measuring coverage of YFHS	*Krishna Bose*
12:40 – 13:00	Discussion period	
14.00 – 15:00	Coverage tools Experience of the Russian Federation	*Krishna Bose* *Tatiana Kozhukhovskaya*
15:00 – 15:30	Group work: Preparation field test: group assignments, division of responsibilities, task overview	
16:00 – 17:30	Questions for field data collection. Rehearsal in pairs. Interactive session	

- **Day 3 – 14 May 2008**

09:00 – 12:00	Field work	
12:00 – 12:30	Plenary session	
12:30 – 13:30	Developing scoring system	
14:30 – 16:30	Feedback on tools. Data entry, analysis	

- **Day 4 – 15 May 2008**

09:00 – 09:20	Integrated YFHS: the role of family medicine	*Trevor Gibbs* *L Khimion* *G. Lysenko*
09:20 – 09:40	Monitoring YFHS Ukraine experience	 *Lydya Romanenko*
09:40 – 10:30	Discussion period	
11:00 – 11:30	Survey implementation: Sampling	 *Krishna Bose*
11:30 – 13:00	Adaptation & pre-testing of tools; team selection; quality control; data entry; analysis	*Paul Bloem*
14:00 – 15:30	Country planning	
16:00 – 17:30	Country planning (continued)	

➢ **Day 5 – 16 May 2008**

09:00 – 1:.30 Feedback: Country teams

11:00 – 12:30 Common issues: financing; technical support needs

12:30 – 13:00 Closing

5 List of participants

G Ahmedjanova
National Reproductive Health Centre, Ministry of Health, Tajikistan

Obidjon Aminov
Chief Specialist, Dept of Medical Services, Ministry of Health, Dushanbe, Tajikistan

Olena Anoprienko
National Trainer, YFHS, Kyiv, Ukraine

Gulnara Atantaeva
Consultative Policlinic Dept., Kyrgyz Scientific Centre for Human Reproduction, Bishkek, Kyrgyzstan

A R Berdialiev
Clinic Hospital of Skin and Venereal Diseases, Tursunzade, Tajikistan

Galina Mikhailovna Bobyr
Head, YFHC, Children's Hospital N=6, Shevchenskyi Rayon, Kyiv, Ukraine

Oksana H. Bogdanova
Students Policlinic, Bishkek, Kyrgyzstan

Ludmila Bologa
Docent, Chair of Paediatrics, State Medical & Pharmaceutical University "Nikolaj Testemitsanu", Chisinau, Republic of Moldova

Galina Eduardovna Chirkina
Reproductive Health Alliance, Kyrgyzstan

Victoria Ciubotaru
Head, Dept Monitoring & Evaluation, National Centre for Health Management, Chisinau, Republic of Moldova

Petru Crudu
Deputy Director, Medical Statistics, Monitoring & Evaluation, National Centre for Health Management, Chisinau, Republic of Moldova

Rakhim Dadabaev
Coordinator, YFHS Association "Zukhra", Dushanbe, Tajikistan

Tetyana Gonchar
Chief Doctor, Shostka City Children's Hospital, Sumskaya oblast, Ukraine

D Dj Huseinova
Dept of Health Services, Government of Dushanbe, Tajikistan

Anara T. Ibraeva
Administration, Fund of Medical Insurance, Bishkek, Kyrgyzstan

S Izatullaeva
YFHS, Health Authority, Javanskiy, Javan, Tajikistan

Sholpan Karzhaubaeva
Deputy Head, National Healthy Lifestyle Centre, Kazakhstan

Gulnara Kulkaeva
Chief Specialist, YFHS Coordinator, National YFHS Coordinator, Astana, Kazakhstan

Kutnevich Lubomira Urievna
Chief, Paediatrician, Health Dept, Lvovskaya oblast, Ukraine

Galina Morari
Adviser, Dept of Mother & Child Health Care, Ministry of Health, Chisinau, Republic of Moldova

Svetlana Moroz
Reproductive Health Specialist, Coordinator of Health Centre for Youth, Chimishlia, Republic of Moldova

Lyudmila Konstantinova Parhomenko
Head, Adolescent Health, Kharkiv Medical Academy of In-Service Training, Ukraine

Valentina Borisovna Pedan
Ministry of Health, Head of Paediatric Department, Ukraine

Gheorghe Railean
Dept of Neuropsychology, Scientific Research Institute For Maternal & Child Health, Chisinau, Republic of Moldova

Lydia Vladimirova Romanenko
Head, YFHS Monitoring Centre, Okhmatdyt Ukranian Hospital, KYIV, Ukraine

Lyubov Anatolievna Semenyuk
Head, YFHS Centre, Children's Policlinic N.2, Chernigov, Ukraine

Raisa Leonidovna Shevchenko
Chief Paediatrician, Zaporozhnyja Health Dept., Zaporozhje, Ukraine

Lyudmila Suk
Deputy Director, Kyiv Social Service for Family, Youth and Sports, Kyiv, Ukraine

Elvira A. Toyalieva
Dept. of Organization of Medical Services, Ministry of Health, Bishkek, Kyrgyzstan

Kutnevich Lubomira Urievna
Chief Paediatrician, Health Dept., Lvuvskaya, Lvov, Ukraine

Zhamilya E. Usupova
Republican Centre for Improving Health, Bishkek, Kyrgyzstan

Temporary Advisors

Tatiana Kozhukhovskaya
Assistant, Adolescent Medicine Dept, St Petersburg State Medical Academy, Postgraduate Studies, St Petersburg Municipal Consultative and Diagnostic Centre "Juventa", St Petersburg, Russian Federation

Christina Rogala
Senior Advisor, Midwife, Swedish Association for Sexual Education, Stockholm, Sweden

Special Advisors

Trevor Gibbs
Executive Director, International Dept., Royal College for Family Physicians, Scotland, United Kingdom

Liudmila Victorovna Khimion
Senior Lecturer, Dept. of Family Medicine, National Medical Academy Postgraduate Education, Kyiv, Ukraine

Grigory Ivanovich Lysenko
Head, Dept. of Family Medicine, National Medical Academy of Postgraduate Education named after P L Shupic, President, Ukrainian Assoc. of Family Medicine, Kyiv, Ukraine

UNFPA

Borys Vornyk
Head, Country Office, Ukraine

UNICEF

Ruslan Malyuta
Program Officer, HIV/AIDS, Regional Office, CEE/CIS, Geneva, Switzerland

Nisso Kasymova
Programme Officer, YPHDP and HIV/AIDS, Tajikistan

World Heath Organization

Paul Bloem
Child and Adolescent Health & Development

Krishna Bose
Child and Adolescent Health & Development
Geneva, Switzerland

WHO Regional Office for Europe

Valentina Baltag
Technical Officer, Adolescent Sexual & Reproductive Health, Country Health Policies & Health Systems, Copenhagen, Denmark

Anastasiya Dumcheva
National Professional Officer, Health Systems, WHO Country Office, Kyiv, Ukraine

Galina Lesco
National Professional Officer, Health Systems, WHO Project Office, Chisinau, Republic of Moldova

Meder Omurzakov
National Professional Officer, Health Systems, WHO Country Office, Bishkek, Kyrgyzstan

Mrs Olga Pettersson
Secretary, Country Health Policies & Health Systems, Copenhagen, Denmark

Igor Pokanevych
Head, WHO Country Office, Kyiv, Ukraine